Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARK JOHNSON, MD
PO BOX 741865
DALLAS, TX 75374

Respondent Name
OLD REPUBLIC GENERAL INSURANCE

Carrier's Austin Representative Box
Box Number 42

MFDR Tracking Number
M4-11-0138-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "REQUIRED TESTING REQUESTED BY THE DD"

Amount in Dispute: $567.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on September 17, 2010 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2010	97750-FC	$567.36	$567.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203 sets out Medical Fee Guidelines for professional services.
4. 28 Texas Administrative Code §130.6 sets out rules for testing to support a Designated Doctor (DD) service.
5. Texas Labor Code Title 5, Subtitle A, Chapter 408, Subchapter A, in §408.0041 provides general provisions for DD Examinations and carrier responsibilities for payment of such services.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 15 – THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.

   Explanation of benefits dated August 2, 2010
   - 15 - THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
   - 45 - CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - BL - THIS BILL IS A RECONSIDERATION OF A PREVIOUSY REVIEWED BILL.

Issues

1. Did the Respondent deny services with "45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT" appropriately?
2. Is authorization required for a DD examination supporting Functional Capacity Evaluation (FCE)?
3. Did the requestor perform and document FCE testing in support of a DD examination per 28 Texas Administrative Codes §134.204(g) and §130.6?
4. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits dated August 02, 2010, the carrier reduced the medical bill because "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT". Because the respondent did not clarify or otherwise address the 45 claim adjustment code upon reconsideration or upon receipt of the request for dispute resolution, the division finds that the 45 claim adjustment code is not supported.
2. The Respondent has denied the services for lack of an authorization with denial code "15 - THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER."

   28 Texas Administrative Code §130.6 which states in part (e):

   "(e) For testing other than that listed in subsection (d) of this section, the designated doctor may perform additional testing or refer the employee to other health care providers when deemed necessary to assess an impairment rating. Any additional testing required for the evaluation and rating, is not subject to preauthorization requirements in accordance with Labor Code §413.014 (relating to Preauthorization) and additional testing must be completed within ten working days of the designated doctor's physical examination of the employee. Use of another health care provider to perform testing under this subsection can extend the amount of time the designated doctor has to file the report by ten working days."

   Texas Labor Code §408.0041 states in (h)(1):

   "(h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a) or (f)."

   Also, 28 Texas Administrative Code 134.204 states in part (g):

   "(g) The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required..."

   The DD examination for which this test was performed was Division (DWC) ordered per Texas Labor Code §408.0041, therefore, the DD examination supporting FCE tests are listed as the exception and are payable per 28 Texas Administrative Code 134.204(g). FCE's for testing in support of a DD do not require an authorization per 28 Texas Administrative Code §130.6(e).
3. Review of the documentation supports that CPT code 97750-FC for a FCE was billed with 16 units, representing 4 hours of testing of injured worker. The documentation supports performance of 40 minutes of Work Simulation Testing, 20 minutes of standing, 20 minutes of sitting, and two questionnaires. There also were 12 separate measurements including strength, vascular, neurological, cardiovascular, reflex evaluations which would support 4 hours of testing.

4. The requestor is entitled to reimbursement according to the 28 Texas Administrative Code §134.203(c) method of calculating reimbursement for 16 units at $44.22 per unit for ZIP Code 76104 in Ft. Worth (Tarrant County). The total MAR is $707.50. The recommended amount is the disputed amount of $567.36.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $567.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $567.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Gregory Fournerat Medical Fee Dispute Resolution Officer	October 11, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.